WYOMING WIC PROGRAM

PHYSICIAN'S AUTHORIZATION FORM FOR SPECIAL FORMULA

Infant: _____ Birthdate: _____

Parent's name: _____

Formula request: _____

Length of time requested: _____

Check box if requested for **three** months: ☐ (Maximum length of time)

Medical Condition: (please circle)

- Failure to thrive
- Asthma
- Organic heart disease
- Vomiting
- Prematurity
- Metabolic disorders
- Allergies
- Colic
- Constipation and intolerance to fat, starch or protein
- Other ICD-9 classified medical diagnosis _____

Physician's Name: _____

Physician's Signature: _____ Date: _____

1/08

WYOMING WIC PROGRAM

PHYSICIAN'S AUTHORIZATION FORM FOR SPECIAL FORMULA

Infant: _____ Birthdate: _____

Parent's name: _____

Formula request: _____

Length of time requested: _____

Check box if requested for **three** months: ☐ (Maximum length of time)

Medical Condition: (please circle)

- Failure to thrive
- Asthma
- Organic heart disease
- Vomiting
- Prematurity
- Metabolic disorders
- Allergies
- Colic
- Constipation and intolerance to fat, starch or protein
- Other ICD-9 classified medical diagnosis _____

Physician's Name: _____

Physician's Signature: _____ Date: _____

1/08